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Thomas More Law Center v. Obama - Amicus Brief of Oregon et al.

State of Oregon

No. 10–2388

In the
United States Court of Appeals
for the Sixth Circuit

THOMAS MORE LAW CENTER, *et al.*,

Plaintiffs-Appellants,

v.

BARACK OBAMA, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Michigan
No. 10–11156 (Steeh, J.)

BRIEF OF THE STATES OF OREGON, IOWA, NEW YORK, CALIFORNIA, VERMONT, HAWAII, MARYLAND, DELAWARE AND CONNECTICUT AS AMICI CURIAE IN SUPPORT OF DEFENDANTS-APPELLEES

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BRIEF OF THE STATES OF OREGON, IOWA, NEW YORK, CALIFORNIA, VERMONT, HAWAII, MARYLAND, DELAWARE AND CONNECTICUT AS AMICI CURIAE IN SUPPORT OF DEFENDANTS-APPELLEES

I. INTERESTS OF THE AMICI STATES

Amici, all of whom are sovereign states of the United States, file this brief pursuant to Federal Rule of Appellate Procedure 29(a).[1] As sovereign states, amici are charged with protecting and promoting the health and welfare of their citizens. Citizen access to affordable medical care is necessary for the states to promote health, prevent disease, and heal the sick. In our modern system of advanced yet costly medical care, comprehensive health insurance coverage is critical to achieving that end. It is well documented that a lack of health insurance coverage leads to increased morbidity, mortality, and individual financial burdens.[2]

In connection with their duties to protect and promote the health and welfare of their citizens, amici have engaged in varied, creative, and determined

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[1] Rule 29(a) provides that "[t]he United States or its officer or agency or a state may file an amicus-curiae brief without the consent of the parties or leave of court." Fed. R. App. P. 29(a).

[2] *See, e.g.*, Stan Dorn, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* (Urban Institute Jan. 2008), available at http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf (last visited Jan. 11, 2011).

state-by-state efforts to expand and improve health insurance coverage in their states and to contain health care costs. Despite some successes, these state-by-state efforts have fallen short. As a consequence, amici have concluded that a national solution is necessary.

Oregon's predicament illustrates the problem that states now face. Despite a variety of legislative efforts to increase access to insurance coverage, 21.8% of Oregonians lack health insurance. Absent health care reform, Oregon expects that figure to rise to approximately 27.4% in the next 10 years.[3] In 2009, Oregon spent approximately $2.6 billion on Medicaid and CHIP. Absent health care reform, that figure is expected to grow to approximately $5.5 billion by 2019.[4]

Other states face similarly dire circumstances. For example, in 2009, over 8 million Californians—nearly one in four people under the age of 65—lacked insurance for all or part of the year.[5] This represents a 28 percent

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[3] Bowen Garrett et al., *The Cost of Failure to Enact Health Reform: Implications for States*, 51 (Robert Wood Johnson Foundation and the Urban Institute Oct. 1, 2009), *available at*: http://www.urban.org/uploadedpdf/411965_failure_to_enact.pdf (last visited Jan. 11, 2011).

[4] *Id.*

[5] Shana A. Lavarreda et al., *Number of Uninsured Jumped to More than Eight Million from 2007 to 2009* (University of California, Los Angeles Mar. 2010), *available at*

Footnote continued…

increase in the number of uninsured Californians from 2007. Moreover, over 5.5 million Californians were enrolled in Medi-Cal or California's Healthy Families Program during 2009.[6] Providing health care benefits to these Californians who would have been otherwise uninsured comes at a considerable cost to the state. The proposed budget for the 2011–2012 Fiscal Year includes $83.5 billion in spending on Health and Human Services, close to 50 percent of which will go to Medi-Cal alone.[7] Of those funds, $ 27.1 billion comes from the General Fund, which is facing a $25 billion deficit. [8]

The situation that states now face is unsustainable. And without national reform, state-level health care costs will rise dramatically over the next 10 years. Even as states are forced to spend more and more to keep up with skyrocketing health care costs, the number of individuals without insurance will continue to rise if the subject health care reform is not implemented.[9]

(…continued)
http://www.healthpolicy.ucla.edu/pubs/files/Uninsured_8-Million_PB_%200310.pdf (last visited Jan. 13, 2011).

[6] *Id.*

[7] 2011–2012 Governor's Budget Summary at 95–96 (Jan. 10, 2011), *available at* http://www.ebudget.ca.gov/pdf/BudgetSummary/FullBudgetSummary.pdf (last accessed Jan. 13, 2011).

[8] *Id.* at 4.

[9] Bowen Garrett et al., *supra* note 3, at 51.

The Patient Protection and Affordable Care Act (ACA) is a national solution that will help amici fulfill their duty to protect and promote the health and welfare of their citizens. The law strikes an appropriate balance between national requirements that promote the goal of expanding access to health care in a cost-effective manner and state flexibility in designing programs to achieve that goal. As the district court correctly concluded, the ACA achieves these goals without running afoul of any constitutional limits on federal government authority. The amici urge this court to affirm the district court's decision.

II. INTRODUCTION

As the district court recognized, the nation's health care system is in a state of crisis. *Thomas More Law Center v. Obama*, 720 F.Supp 882, 893 (E.D. Mich. 2010). As of 2008, 43.8 million people in the United States had no health insurance coverage and thus no or little access to health care.[10] Indeed, Congress found that "62 percent of all personal bankruptcies are caused in part by medical expenses." ACA § 1501(a)(2)(G).[11] And state-level health care costs will only continue to rise. These increases threaten to overwhelm already

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[10] The Centers for Disease Control and Prevention, Early Release of Selected Estimates Based on Data From the 2008 National Health Interview Survey Table 1.1a (2009), *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/200906_01.pdf (last visited Jan. 11, 2011).

[11] All references to ACA § 1501(A)(2) are to §1501 as amended by § 10106 of the ACA.

overburdened state budgets. Without a national solution to the health care crisis, the amici states would be forced for the foreseeable future to spend more and more on health care and yet still slide further and further away from their goal of protecting the health and well-being of their citizens.

The ACA will allow states to expand and improve health insurance coverage. The ACA achieves coverage increases through a variety of mechanisms, including the implementation of a minimum coverage provision that requires most residents of the United States, starting in 2014, to obtain health insurance or pay a tax. But among other exceptions, the minimum coverage provision does not apply to those whose income falls below a specified level or to those who can demonstrate that purchasing insurance would pose a hardship.[12] In other words, the minimum coverage provision is targeted at those who, while they can afford it, choose not to purchase insurance and choose instead to "self insure," relying on luck, their own financial reserves, and the health care social safety net of emergency rooms and public insurance programs to catch them when they fall ill.

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[12] Individuals who will not be subject to the individual mandate include those with incomes low enough that they are not required to file an income tax return (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples), those who would have to pay more than a certain percentage of their income (8% in 2014) to obtain health insurance, and those who can demonstrate that purchasing insurance would pose a hardship. ACA § 1501(e).

Appellants, who have chosen "not to purchase health insurance or obtain the government-mandated level of coverage required by the Act," agree that the health care insurance market is in "need of repair." Appellants' Br. 14, 30. They further agree that the health care insurance market generally falls within the Commerce Clause. Appellants' Br. 30. They nevertheless maintain that the individual coverage provision exceeds Congress's Commerce Clause power. As Appellants frame their argument, the Commerce Clause empowers Congress to regulate only activity and not, as they characterize it, the "inactivity" of refusing to purchase health insurance. But appellants ignore the effect on interstate commerce of refusing to comply with the minimum coverage provision and thus mischaracterize the conduct for which they seek this Court's imprimatur as "inactivity." Moreover, they lose sight of the principal concern that animates the Supreme Court's Commerce Clause jurisprudence, namely, ensuring a meaningful distinction between what is truly national and what is truly local. For the reasons explained below, the minimum coverage provision fits easily within Congress's Commerce Clause authority.

III. THE ACA'S MINIMUM COVERAGE PROVISION IS CONSTITUTIONAL.

A. The minimum coverage provision is necessary for the success of health care reform and the overall stability of the nation's health insurance markets.

Any fair review of Congress's authority under the Commerce Clause to enact the minimum coverage provision must be conducted in the context of

examining why the minimum coverage provision is crucial to national health care reform. One of the primary goals of the ACA is to increase the number of Americans who have access to health insurance coverage. Insurance is a system of shared risk. But in a system where purchasing insurance is purely voluntary, people with higher than average health risks will disproportionately enroll in insurance plans, as an individual is more likely to purchase insurance when he or she expects to require health care services. This phenomenon is commonly referred to as "adverse selection."

Adverse selection raises the cost of insurance premiums for two reasons: first, because adverse selection tends to create insurance pools with higher than average risks and premiums reflect the average cost of providing care for the members of the pool, the overall cost is higher. Second, because insurers fear the potentially substantial costs associated with individuals with non-obvious high health risks disproportionately enrolling in their insurance plans, insurers will often add an extra loading fee to their premiums, particularly in the small group and individual markets. An individual mandate addresses both of these problems, first by driving low-risk people into the risk pool, thus driving down average costs, and second by lessening the probability that a given individual is purchasing insurance solely because he or she knows something the insurer does not know about his or her health status, thereby reducing insurer hedging and the fees associated with adverse selection.

Another consequence of adverse selection is that insurers enact a variety of policies designed to keep high-cost individuals out of their plans and limit the financial cost to the plan if those individuals enroll—such as limiting coverage for preexisting conditions, denying coverage, charging higher premiums for those with actual or anticipated health problems, and imposing benefit caps. While some states have attempted to grapple with this problem by establishing programs such as California's Major Risk Medical Insurance Program, which covers otherwise "uninsurable" individuals, these programs are often prohibitively expensive.[13] The ACA seeks to eliminate many of these adverse-selection avoidant practices by outlawing preexisting condition exclusions and requiring insurers to issue policies to anyone who applies.

These reforms are, of course, designed to increase access to insurance. However, the reality is that "[i]nsurance pools cannot be stable over time, nor can insurers remain financially viable, if people enroll only when their costs are expected to be high. . .[a]nd research leaves no doubt that without an individual mandate, many people will remain uninsured" until they get sick.[14] Young Americans are especially inclined to forgo purchasing health insurance in favor

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[13] *See* Cal. Ins. Code, § 12710 *et seq*.; Jordan Ru, *Few Can Use State High-Risk Pool for Uninsured*, Los Angeles Times, Oct. 28, 2008.

[14] Linda J. Blumberg & John Holahan, *The Individual Mandate—An Affordable and Fair Approach to Achieving Universal Coverage*, 361 New Eng. J. Med. 6, 6–7 (2009).

of other consumption. In California, for instance, 18 to 34 year-olds represent 43 percent of the state's uninsured.[15] If pre-existing conditions are eliminated with no requirement that one purchase insurance, these people would have an incentive to forgo coverage until they get sick—and the high-risk pool would collapse from inadequate funding.[16] A minimum coverage requirement that requires everyone to pay into the risk pool will dramatically reduce adverse selection, and make it practical to insist upon coverage for individuals with pre-existing conditions.

B. The minimum coverage provision fits within Congress's authority under the Commerce Clause and the Necessary and Proper Clause.

1. Congress has broad authority to regulate activities that substantially affect interstate commerce.

The United States Constitution empowers Congress to "make all Laws which shall be necessary and proper" to "regulate Commerce . . . among the several States." U.S. Const. art. I § 8, cl. 3. The Commerce Clause power includes the authority to "regulate those activities having a substantial relation to interstate commerce, . . . *i.e.*, those activities that substantially affect

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[15] California HealthCare Foundation, *California's Uninsured* at 18 (Dec. 2010), *available at* http://www.chcf.org/publications/2010/12/californias-uninsured (last visited Jan. 13, 201).

[16] *See* Michael C. Dorf, *The Constitutionality of Health Insurance Reform, Part II: Congressional Power* (Nov. 2, 2009), *available at* http://writ.news.findlaw.com/dorf/20091102.html (last visited Jan. 11, 2011).

interstate commerce." *United States v. Lopez*, 514 U.S. 549, 558–59 (1995) (internal citations omitted).

The Supreme Court has long understood the Commerce Clause to be an exceptionally wide grant of authority. In that regard, three important principles have emerged from the Court's cases that are relevant here. First, an activity will be deemed to have a "substantial effect" on interstate commerce if the activity, when aggregated with the similar activity of many others similarly situated, will substantially affect interstate commerce. *Wickard v. Filburn*, 317 U.S. 111, 128 (1942). Second, local, non-economic activities will be held to affect interstate commerce substantially if regulation of the activity is an integral or essential part of a comprehensive regulation of interstate economic activity, and if failure to regulate that activity would undercut the general regulatory scheme. *Gonzalez v. Raich*, 545 U.S. 1, 18 (2005). Third, in determining whether a regulated activity substantially affects interstate commerce within the meaning of the Commerce Clause, the Court "need not determine whether . . . [the regulated activities] taken in the aggregate, substantially affect interstate commerce in fact, *but only whether a 'rational basis' exists for so concluding*. *Id.* at 22 (emphasis added). Congress's judgment that an activity would undermine the statutory scheme "is entitled to a strong presumption of validity." *Id*. at 28.

Although the Commerce Clause authority to regulate interstate commerce is thus broad, it is not without limits. Courts will not "pile inference upon inference" to find that a local, noncommercial activity that is not part of a comprehensive regulatory scheme nonetheless substantially affects interstate commerce. *Lopez*, 514 U.S. at 567. In *Lopez*, the Court struck down the federal Gun-Free School Zones Act which prohibited carrying of a gun within 1,000 feet of a school. In finding the statute outside of the authority of the Commerce Clause, the Court observed that the act at issue was a criminal statute that had "nothing to do with 'commerce' or any sort of economic enterprise" and was "not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Id.* at 561. *See also United States v. Morrison*, 529 U.S. 598, 615 (2000) (sustaining Commerce Clause challenge to statutory provision creating federal civil remedy for victims of gender-motivated violence).

Lopez and *Morrison* notwithstanding, the Supreme Court's more recent cases have reaffirmed the broad reach of Congress's commerce clause authority. In *Raich*, for example, the Court upheld federal power to prohibit the wholly intrastate cultivation and possession of small amounts of marijuana for medical purposes, despite express state policy to the contrary. 545 U.S. at 31–32. Expressly reaffirming its holding in *Wickard*, the *Raich* Court

concluded that Congress had a rational basis for concluding that marijuana cultivation is an "economic activity" that, in the aggregate, has a substantial effect on interstate commerce. *Raich* also makes clear that Congress may "regulate activities that form part of a larger regulation of economic activity." *Id*. at 24. In other words, Congress can regulate wholly intrastate activity to make effective a comprehensive regulation of an interstate market. *Id*. at 36 (Scalia, J., concurring). Even if an activity is "'local and though it may not be regarded as commerce, it may still, *whatever its nature*, be reached by Congress if it exerts a substantial economic effect on interstate commerce.'" *Id.* at 17 (quoting *Wickard*, 317 U.S. at 128) (emphasis added).

Congress's broad commerce power is also rooted in the Necessary and Proper Clause. That clause authorizes the federal government to enact regulations that, while not within the specifically enumerated powers of the federal government, are nonetheless "'necessary and proper for carrying into Execution' the powers 'vested by' the 'Constitution in the Government of the United States.'" *United States v. Comstock*, 130 S.Ct. 1949, 1954 (2010) (quoting U.S. Const. Art. I, § 8, cl. 18). In other words, the Necessary and Proper clause permits Congress to enact regulations that are necessary or convenient to the regulation of commerce. In *Comstock*, the Supreme Court recently explained that the Necessary and Proper clause provides federal regulatory authority where "the means chosen are reasonably adapted to the

attainment of a legitimate end under the commerce power or under other powers that the Constitution grants Congress the authority to implement." *Comstock*, 130 S.Ct. at 1957.

2. The minimum coverage provision is constitutional because it regulates activity that substantially affects interstate commerce and because it is an essential part of comprehensive regulation of interstate economic activity.

a. The minimum coverage provision regulates activity that substantially affects interstate commerce.

In the ACA, Congress specifically found that the minimum coverage requirement is "commercial and economic in nature, and substantially affects interstate commerce." ACA § 1501(a)(1).[17] Congress certainly had a rational basis for reaching that conclusion. An individual's decision to purchase—or not purchase—health insurance is an economic activity that, when taken together with the activities of all individuals similarly situated, substantially affects the market for health insurance and health care. Appellants claim that an individual who fails to purchase health insurance "is neither engaged in economic activity nor in any other activity that would bring him or her within the reach of even a legitimate regulator scheme." Appellants' Br. at 29. But this assertion is contradicted by the reality of the health care and health insurance markets, where the aggregated purchasing decisions of individuals

[17] *See also* ACA § 1501(a)(2) (describing the effects of the minimum coverage requirement on the national economy).

who choose not to maintain health insurance—because they cannot afford it or for some other reason—have a powerful and generally adverse impact on those markets. In the aggregate, these economic decisions regarding how to pay for health care services—including, in particular, decisions to forgo coverage and to pay later or, if need be, to depend on free care—have a substantial effect on the interstate health care market. As the Supreme Court recognized in *Raich* and in *Wickard*, the Commerce Clause empowers Congress to regulate these direct and aggregate effects. *See Raich*, 545 U.S. at 16–17; *Wickard*, 317 U.S. at 127–28.

When individuals choose not to purchase health insurance, they are still participants in the interstate health care marketplace. When the uninsured get sick, they seek medical attention within the health care system. The medical care provided to the uninsured costs a substantial amount of money. Approximately one third of the cost of that care is covered by the uninsured themselves. The remaining two thirds of the cost are passed on to other public and private actors in the interstate health care and health insurance system, including the state and federal governments, multi-state private insurance companies, and large multi-state employers. Although researchers disagree as

to the price tag for uncompensated care, it is generally agreed that the cost is substantial—billions of dollars each year.[18]

California's experience illustrates the financial impact of the uninsured on the health care market. Because the uninsured are often unable to pay their medical bills, providers shift those costs onto the insured. Experts have estimated that this so-called "hidden tax" amounts to $455 per individual or $1,186 per family each year.[19] Hospitals foot this bill as well. In 2008, uncompensated care in California constituted between 5 and 7 percent of public hospitals' operating expenses and 3 percent of private hospitals' operating expenses.[20] To put this figure in perspective, public hospitals have a median net income margin between 0.04% and 2.5%, whereas private hospitals have a median net income margin between 2.4 percent and 5 percent.[21]

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[18] *See, e.g.*, Dianne Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. Med. & Ethics 397, 402 (2004); Susan A. Channick, *Can State Health Reform Initiatives Achieve Universal Coverage? California's Recent Failed Experiment*, 18 S. Cal. Interdisc. L.J. 485, 499 (2009).

[19] Peter Harbage and Len M. Nichols, Ph.D., *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System* (New America Foundation, Dec. 2006).

[20] California HealthCare Foundation, *California's Health Care Safety Net: Facts and Figures* at 19 (Oct. 2010), *available at* http://www.chcf.org/publications/2010/10/californias-health-care-safety-net-facts-and-figures (last accessed Jan. 13, 2011).

[21] *Id*. at 22.

The cost of the uncompensated care provided to the uninsured is magnified by the fact that the uninsured frequently delay seeking care. By the time they are treated, their medical problems are often more costly to treat than they would have been had they sought care earlier.[22] Furthermore, because emergency rooms are required by federal law to screen everybody who walks through their doors and to provide stabilizing treatment to those with an emergency medical condition, much of the care for the uninsured is delivered in this costly and inefficient setting. Indeed, treatment in an emergency room costs approximately three times as much as a visit to a primary care physician, at a cost of approximately $4.4 billion across the United States.[23]

In addition to the direct impact on the health care and health insurance systems, individuals who choose to forgo insurance affect the national economy in other ways, including lost productivity due to poor health and personal

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[22] *Hearings to Examine Health Care Access and Affordability and Its Impact on the Economy: Before the Subcomm. on Labor, Health and Human Services, Education, and Related Agencies of the S. Comm. on Appropriations*, 108th Cong. (2003) (testimony of Jack Hadley, Urban Institute), *available at* http://ftp.resource.org/gpo.gov/hearings/108s/89058.txt (last visited Jan. 19, 2011).

[23] California Association of Health Plans, *10 Factors Driving Costs for California's Hospitals* at 3 (Nov. 2010), *available at* http://www.calhealthplans.org/documents/IssueBriefHospitalCostDriversNovember2010.pdf (last accessed Jan. 13, 2011); *see also* USC Center for Health Financing, Policy, and Management, *Marginal Costs of Emergency Department Outpatient Visits: An update using California data* (Nov. 2005) *available at* ww.usc.edu/schools/sppd/research/healthresearch/images/pdf_reportspapers/multivariate_cost_paper_v5.pdf (last accessed Jan. 13, 2011).

bankruptcies due to health care costs, and some of the limited health care resources are shifted to emergency departments, rather than to preventative care.[24] In the aggregate, economic decisions regarding how to pay for health care services, particularly decisions to forgo coverage, have a substantial effect on the interstate health care market, because the costs of providing care to the uninsured are passed on to everyone else through higher premiums, on average, over $1,000 a year, and higher health care costs. ACA § 1501(a)(2)(F).

b. The minimum coverage provision is an essential part of comprehensive regulation of interstate economic activity.

Appellants' Commerce Clause challenge also fails because the minimum coverage provision is an essential part of comprehensive regulation of the health care and health insurance industries. Health insurance and health care are both economic activities in interstate commerce that are indisputably within Congress's Commerce Clause power to regulate. Seventeen percent of the United States economy is devoted to health care. ACA § 1501(a)(2)(B). More than 11 million people work in the US health care industry.[25] The federal

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[24] Kaiser Family Foundation, *Hospital Emergency Room Visits per 1,000 Population, 1999, available at*

http://www.statehealthfacts.kff.org/comparetrend.jsp?yr=6&sub=94&cat=8&ind=388&typ=1&sort=a&srgn=1 (last visited Jan. 12, 2011). From 1999 to 2008, emergency room visits rose from 365 to 404 per 1,000 population as uninsured rates increased.

[25] Kaiser Family Foundation, *Total Health Care Employment, 2009, available at*

Footnote continued…

government has for decades been deeply involved in healthcare regulation, including, among other programs Medicare, Medicaid, and CHIP. As the Supreme Court recently recognized, such a longstanding history helps to illustrate "the reasonableness of the relation between the new statute and pre-existing federal interests." *Comstock*, 130 S. Ct. at 1958.

The minimum coverage provision is an essential component of creating an affordable, accessible, and robust insurance market that all Americans can rely on—the central goal of the ACA. As explained above, Congress's purpose in including the minimum coverage provision was to combat the problem of adverse selection. It does that by incorporating healthy people into the risk pool, thus driving down average costs. Moreover, without a minimum coverage provision, it would be impossible to prohibit insurers from excluding from coverage individuals with pre-existing conditions. In short, the minimum coverage provision is an integral part of the ACA's "comprehensive framework for regulating" healthcare, the absence of which would severely undercut Congress's regulatory scheme. It is therefore constitutional under *Raich*. ("Congress can . . . regulate purely intrastate activity that is not itself "commercial," . . . if it concludes that failure to regulate that class of activity

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(…continued)
http://www.statehealthfacts.org/comparemaptable.jsp?ind=445&cat=8 (last visited Jan. 11, 2011).

would undercut the regulation of the interstate market in that commodity." *Raich*, 545 U.S. at 3.).

For the same reasons, the minimum coverage provision is a means "reasonably adapted" to achieving "a legitimate end under the commerce power." *Comstock*, 130 S. Ct. at 1957. There can be no dispute that creating an affordable and accessible health insurance market is a legitimate Congressional goal, and one well within the scope of its commerce clause authority. The minimum coverage provision is a reasonably adapted means to that end. The provision is therefore a "necessary and proper" regulation that Congress is empowered to enact. *Id.*

CONCLUSION

Congress plainly has the power to enact the ACA. This Court should therefore uphold the district court's order dismissing appellants' complaint.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32 (a)(7), I certify that the forgoing Brief is proportionately spaced, has a typeface of 14 points or more and contains 4,211 words.

DATED: January 21, 2011

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CERTIFICATE OF SERVICE

I hereby certify that on January 21, 2011, I directed the Brief of the States of Oregon, Iowa, New York, California, Vermont, Hawaii, Maryland, Delaware and Connecticut as Amici Curiae in Support of Defendants-Appellees to be electronically filed with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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